LD — 074570

APPLICATION — PART I — TO NEW-YORK LIFE INSURANCE COMPANY

PROPOSED INSURED? Print full name: LERAH EUGENE (SKIP) HALL
DATE OF BIRTH? Mo: Day Yr:
AGE nearest Birthday?
Male? Fem.?
Single? ☐ Married? ☑ Sep.? ☐ Div.? ☐ Wid.? ☐ Place of Birth? (State or Prov. and Country) KANSAS

ADDRESS? Number St. or Rt. City or Town County State or Province Time at Address?
Residence 72 SIERRITA ST KERNVILLE KERN CALIF Yrs 4 Mos:
Business DUFFY FRONTIER VILLAGE, WOFFORD HTS KERN COUN Yrs: 1 Mos:
FIRM OR EMPLOYER? WALTER DUFFY INTER, WOFFORD HTS CALIFORNIA
Mailing Address? Res. ☑ Bus. ☐ Other BOX 74 KERNVILLE, CALIF
If in Military Service, Pay Grade and Permanent Mailing Address?
Present Occupation(s)? BARTENDER
Duties of Occupation(s)? ON SHIFT
Previous Occupation(s) within last 2 years? MOTEL OWNER
Previous Address(es) within last 2 years? Residence:
Business: RAINBOW MOTEL, KERNVILLE, KERN, C

LIFE PLAN and AMOUNT?
W.P. Yes ☐ No ☐
P.P.O. Yes ☐ No ☐
C.P.B. Yes ☐ No ☐ A.D.B. $ F. Inc. (Yr.) $ Mo.
P.P.B. Yes ☐ No ☐ Term (Yr.) $ M.P. (Yr.) Units.

APL? Yes ☐ No ☐
LIFE Dividend option? Cash ☐ Add'n ☐ Prem. ☐ Dep. ☐ Dep. & 1 Y. T. Opt. ☐

LIFE Policy to be dated?
Later date of Parts I and II ☐
Date policy written ☐
Other 19

HEALTH PLAN and AMOUNT? 120 DAY MAX. BEN. PERIOD 1000 MISC BEN 600 SURGERY
Monthly Disability Income $; Day Benefits Commence: Accident Sickness
Daily Hospital Benefit $ ~~15.00~~ $20.00 Deductible Amount $ ~~50.00~~ 25.00
Maximum Major Medical Benefit $; Deductible Amount $

HEALTH Policy to be dated?
Later date of Parts I and II ☐
Date policy written ☑
Other 19

4. PREMIUM MODE
LIFE HEA
☐ C-O-M
☐ Nyl-a
☐ Mthly
☐ Qrtly
☐ Semi
☐ Ann'l
☐ Gov't
☐ S.P.

5. BENEFICIARY, subject to change. Full Name & Relationship to Proposed Insured?
LIFE
HEALTH

6. LIFE Policy Owner?
Proposed Insured ☐
Other ☐
(If "Other" complete question 15)

7. CASH PAID subjec terms of receipt bel (If none paid, say "n
LIFE Policy $
HEALTH Policy $ 17.00

8. Has any person proposed for coverage (see Question 14):
(a) ever been declined for issue, reinstatement, or renewal of any type of Life or Health insurance, or been offered a policy on issue, reinstatement or renewal which was different from that applied for? Yes ☐ No ☑
(If "Yes", give name of person, companies and other details below.)
(b) flown within last 5 years, or intend to fly, as a pilot or other crew member of any kind of aircraft? Yes ☐ No ☑
(If "Yes", complete aviation blank, Form 5794, as part of this application.)
(c) resided within last 5 years, or intend to reside, outside the United States and Canada? (If "Yes", state where, when and how long.) Yes ☐ No ☑
(d) engaged in within last 5 years, or intend to engage in, skin diving, motor vehicle racing, sky diving, or any other hazardous sport or hobby? Yes ☐ No ☑
(If "Yes", complete Form 7663.)

9. Is the policy(s) applied for intended to replace, in whole or in part, L Health insurance in force in this or any other company? Yes ☐ N
(If "Yes", give name of company, replacement date, amount of bene placed, plan and policy number, if known.)

10. Insurance in force or pending on Proposed Insured? (If none, say "n
(a) If life policy being applied for, total amount of life insurance
In Force None Pending
(b) If health policy being applied for, amount of health insurance

Mthly Inc. (Disability)	Daily Ben. (Hospital)	Max. Ben. (Maj. Med.)	In Force	Pending	Compan Organiz

11. Amendments and Corrections (for completion at Home Office; this space will not be used where not allowed by Statute or Insurance Department Regula

IT IS MUTUALLY AGREED THAT:

1. Except as provided in a receipt, the terms of which are mutually acceptable, given for cash and bearing the same date and number as Part I of this application, no policy applied for herein shall go into force or take effect unless and until it is delivered to the Applicant and the first premium for it is paid in full during the lifetime of the person or persons proposed for coverage under it, and then only if the written representations made in the entire application for insurance would be, without material change, at time of delivery of the policy, true and complete representations of the state, at that time, of those matters inquired about in such application.
2. No field underwriter or other agent of the Company, nor any medica iner, is authorized to accept risks, pass upon insurability, make or contracts, or waive any of the Company's rights or requirements.
3. The Applicant agrees that the written representations made in such tion are correctly recorded, complete and true and that the C believing them to be true, shall rely and act upon them accordin Applicant confirms all agreements included in such application and that acceptance of any policy issued thereon shall constitute ratific such agreements and of any amendments and corrections which t pany has made under item 11 above.

Dated at Wofford Hts. on 1st July 1967
Witnessed by Field Underwriter
Countersigned by
Licensed resident agent where required by statute or regulation.

Applicant R. E. Skip Hall
Proposed Insured* if other than Applicant
Proposed Insured's Spouse if proposed for life coverage X
*"Name" instead of "Signature" if Proposed Insured is a child who can